

Group Medical Direct Reimbursement Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare



PPO CLAIM FORM

MAIL THIS FORM TO: CIGNA HealthCare Service Center
P.O. Box 2100
Bourbonnais, IL 60914

TELEPHONE:

1-800-828-7622 Toll Free

(815) 939-4566 Local Calls

(815) 939-4073 FOR PROVIDER INFORMATION & BENEFIT VERIFICATION

Provider Section, Instructions and Mailing Information on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section			
A. EMPLOYEE'S NAME (First, M.I., Last)		B. DATE OF BIRTH	C. SEX <input type="checkbox"/> M <input type="checkbox"/> F
D. EMPLOYEE'S MAILING ADDRESS (Street, City, State, Zip) and DAYTIME PHONE #		IS THIS A CHANGE OF ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
F. MARITAL STATUS	G. POLICY/ACCOUNT NO. 0343767	H. DIVISION/BRANCH OR CLASS/LOCATION	
I. EMPLOYER URA		J. EMPLOYEE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> HOURLY <input type="checkbox"/> RETIRED <input type="checkbox"/> COBRA <input type="checkbox"/> SALARIED <input type="checkbox"/> DISABLED	
DATE			
PATIENT INFORMATION: Complete Only if Patient is Other Than Employee			
A. PATIENT'S NAME (First, M.I., Last)		B. RELATIONSHIP TO EMPLOYEE	C. DATE OF BIRTH
			D. SEX <input type="checkbox"/> M <input type="checkbox"/> F
E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD		DEPENDENT CHILD IS: <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL-TIME	
NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER			
ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury			
A. DESCRIPTION OF <input type="checkbox"/> ACCIDENT OR <input type="checkbox"/> ILLNESS (How, When, Where)		B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS	D. INJURY DUE TO AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FAMILY/OTHER COVERAGE INFORMATION: Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect			
A. SPOUSE EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	B. NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH
C. SPOUSE'S SOC. SEC. / ID NO.		D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER	
E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS. <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME & ADDRESS			POLICY NUMBER
REIMBURSEMENT ACCOUNT CLAIM INFORMATION: Complete Only if you are a Reimbursement Account Participant			
IF YOU PARTICIPATE IN A HEALTHCARE REIMBURSEMENT ACCOUNT, DO YOU WANT UNPAID AMOUNTS FROM THE ATTACHED EXPENSES SUBMITTED TO YOUR REIMBURSEMENT ACCOUNT FOR REIMBURSEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
A. If requesting reimbursement of expenses from a Healthcare Reimbursement Account, I certify that I or my eligible dependents have incurred these expenses and that these expenses have not been reimbursed from any other source, nor do I expect them to be. I agree to notify the Plan Administrator immediately in the event any of these expenses are reimbursed from another source.			
B. I understand that if I or my eligible dependents have benefits under another plan, I must submit the attached expenses to the other plan for payment and provide proof of denial before the expenses will be considered for reimbursement from my Reimbursement Account.			
EMPLOYEE'S SIGNATURE			DATE

Note: Please Complete Additional Employee/Patient Information on Reverse Side

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims																														
A. AUTHORIZATION TO RELEASE INFORMATION- I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature.																														
PATIENT'S SIGNATURE (Parent or Guardian if Claim is on a Minor)					DATE																									
B. PAYMENT AUTHORIZATION - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.			IF YES, EMPLOYEE'S SIGNATURE	DATE																										
C. CERTIFICATION I certify that this information is true and correct.			EMPLOYEE'S SIGNATURE	DATE																										
PHYSICIAN or PROVIDER: Complete This Section																														
Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code. 1. 2. 3. 4.			DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		DATE FIRST CONSULTED FOR THIS CONDITION																									
			DATE ABLE TO RETURN TO WORK		TOTAL DISABILITY DATES																									
			FROM		TO																									
			NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE																											
HOSPITAL CONFINEMENT DATES		PARTIAL DISABILITY DATES																												
FROM		TO		FROM																										
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YOUR PATIENT'S ACCOUNT NO.		PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING. TAX I.D. # SOC. SEC. #		PHYSICIAN OR PROVIDER'S NAME AND ADDRESS																										
				TOTAL CHARGE																										
				AMOUNT PAID																										
		PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER ()		BALANCE DUE																										
I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.			PHYSICIAN'S OR PROVIDER'S SIGNATURE		DATE																									
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INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

YOU SHOULD SUBMIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN \$200.00; BUT YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.

1. IMPORTANT

- A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- Your claim cannot be processed without your Social Security Number (Employee Section, Block E).
- You must sign and date your claim form (Employee's / Patient's Signature and Release Section).

2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .

Surgery Doctor's Visits Mental Illness Expenses Hospital Confinement

Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).

3. IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:

ALL BILLS

Employee Name	Date of Service
Patient Name	Diagnosis
Type of Service	Charge for Service

DRUG BILLS

(Please tape to an 8 1/2" x 11" piece of paper)

Patient Name	Prescription Date
Physician Name	Drug Name
Prescription Number	Charge

- Be certain to include Physician or Tax Identification number.
- Bills will not be returned to you - make copies for your records.
- Receipts, balance due statements and cancelled checks are not acceptable.

4. ADDITIONAL INFORMATION

Save your Explanation of Benefits - duplicate vouchers are not available.

Second Opinion Surgical Program - Call your benefits counselor for details.

5. MAILING INSTRUCTIONS

Send your **completed claim form** and itemized bills to the address indicated on the front of this form.